SERFF Tracking Number:	*GHPI-126234201*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*42938*
Company Tracking Number:	*GSAPP09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*App09*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: App09	SERFF Tr Num: GHPI-126234201	State: ArkansasLH
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed	State Tr Num: 42938
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num: GSAPP09	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Geneva Clark, Anita Carter	Disposition Date: 07/22/2009
	Date Submitted: 07/21/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/22/2009	Explanation for Other Group Market Type:
	State Status Changed: 07/22/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

(314) 506-1928

acarter@cvty.com

July 20, 2009

SERFF Tracking Number:	*GHPI-126234201*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*42938*
Company Tracking Number:	*GSAPP09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*App09*		
Project Name/Number:	*/*		

Rosalind Minor
Sr. Certified Rate & Form Analyst
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, Arkansas 72201

Re: Co Tracking #: GSAPP09
Form #: MGSA_0609 CHARK 00007
Application/Health Statement Form

Dear Ms Minor:

I am writing on behalf of Coventry Health and Life Insurance Co. (“CHL”) regarding submission of the above referenced document.

The intended market for this document is the individual market. This document is a new, rather than replacement document. This document will be issued to individuals.

In addition, please note the following:
1. A check in the amount of $20.00 will be sent under separate cover as per our email discussion on September 25, 2008 for this filing.
2. In compliance with ACA 23-79-206, a Readability Certificate is attached.
3. In compliance with Rule & Regulation 19, this document does not discriminate on the basis of sex.

Thank you for your assistance with this filing. If you have any comments or concerns, please contact me at (314) 506-1928.

Sincerely,

SERFF Tracking Number:	*GHPI-126234201*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*42938*
Company Tracking Number:	*GSAPP09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*App09*		
Project Name/Number:	*/*		

Anita J. Carter, RN

Manager, Regulatory Compliance

Company and Contact

Filing Contact Information

Anita Carter, Manager of Regulatory Compliance	acarter@cvty.com	
550 Maryville Centre Drive	(314) 506-1928 [Phone]	
St. Louis, MO 63141-5818	(314) 506-1672[FAX]	

Filing Company Information

Coventry Health and Life Insurance Company	CoCode: 81973	State of Domicile: Delaware
6705 Rockledge Drive	Group Code: 1137	Company Type:
Suite 900		
Bethesda, MD 20817	Group Name:	State ID Number:
(314) 506-1700 ext. [Phone]	FEIN Number: 75-1296086	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*GHPI-126234201*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*42938*
Company Tracking Number:	*GSAPP09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*App09*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/22/2009	07/22/2009

SERFF Tracking Number:	*GHPI-126234201*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*42938*
Company Tracking Number:	*GSAPP09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*App09*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/22/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GHPI-126234201*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*42938*
Company Tracking Number:	*GSAPP09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*App09*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application/Health Statement Form	Approved-Closed	Yes

SERFF Tracking Number:	*GHPI-126234201*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*42938*
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TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*App09*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MGSA_0609 CHARK 00007	Application/ Enrollment Form	Application/Health Statement Form	Initial			MGSA_0609 CHARK 00007.pdf

[CoventryOne.] Application / Health Statement Form

[Underwritten by [Coventry Health and Life; <Plan underwriting body>]]

FOR INTERNAL USE ONLY
[EL CODE_____]
☐ ACH [☐ NON-ACH]
[☐ HSA OPT-OUT][☐ PDP]

[Submit completed Application / Health Statement Form to: <Plan> address/fax]

To ensure timely processing of this Application:

√ [Use only blue or black ink]
√ All questions must be answered completely and accurately
√ The Application must be signed and dated in each required section by all required Applicants
√ All corrections must be initialed and dated [; correction fluid is not permitted]
√ This Application is valid sixty (60) days from the earliest date of signature in the [Conditions of Enrollment] section.

FOR [BROKER] USE ONLY
Amount quoted for requested effective date:
$_____ / Month
[☐ Individual ☐ Family]

[Payroll Deduction Program (PDP)
☐ Not Applicable
Name of PDP _____**]**

Check all that apply:

☐ New Application [☐ Plan Benefits Increase] [☐ Plan Benefits Decrease] [☐ Dependent Add]
[☐ Reinstatement] [☐ Guarantee Issue] ☐ New Minor Child-Only Application (under 18 years old)

REQUESTED EFFECTIVE DATE
☐ 1st day of _____20_____
[☐ ___ day of _____20_____]
[☐ 15th day of _____20_____]

APPLICANT AND DEPENDENT INFORMATION

PRIMARY APPLICANT If Minor Child-Only Application, complete information about the child(ren)'s parent or legal guardian in this section.

Last name	First name			MI	Home phone ( ) -
Residence address	City	State	ZIP code	County	
E-mail address	[Occupation / Title]			Business phone ( ) -	
Best time and place to receive a call from <Plan> regarding this Application, if necessary: ☐ Home ☐ Business ☐ Other (____)_____ ☐ Morning ☐ Afternoon ☐ Evening				Relationship (if Minor Child-Only Application)	
Mailing address (If different from address above)	City	State	ZIP code		

PRIMARY APPLICANT'S SPOUSE (If applying for coverage in this Application)

Last name	First name			MI	Home phone ( ) -
Residence address	City	State	ZIP code	County	
E-mail address	[Occupation / Title]			Business phone ( ) -	
Best time and place to receive a call from <Plan> regarding this Application, if necessary: ☐ Home ☐ Business ☐ Other (____)_____ ☐ Morning ☐ Afternoon ☐ Evening					
Mailing address (If different from address above)	City	State	ZIP code		

Applicant Name:_____ **Broker:**_____

PRIMARY APPLICANT AND ALL DEPENDENTS APPLYING FOR COVERAGE

1. Are all persons applying for coverage in this Application legal residents of the United States? ☐ Yes ☐ No

2. Have all persons applying for coverage in this Application legally resided in the United States for the past six (6) consecutive months? ☐ Yes ☐ No

   If no, indicate person(s): _____

   Country of residency:_____ Date of entry into the United States (mm/yyyy) _____

3. To be eligible for coverage, care must be established with a physician located in the United States as of the date of this Application. Has care been established with a physician located in the United States for all persons applying for coverage in this Application? ☐ Yes ☐ No

   If no, indicate person(s): _____

4. List Primary Applicant and all Dependents applying for coverage in this Application:

Full Name (Last, First, MI)	Gender (circle one)	Relationship to the Primary Applicant	Age	Birthdate (mm/dd/yyyy)	Disabled dependent?[1]	Social Security Number[2]	Height (ft. in.)	Weight (lbs)	Tobacco use?[3]
1.	M / F	SELF			N/A				☐ Yes ☐ No
2.	M / F	SPOUSE			N/A				☐ Yes ☐ No
3.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
4.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
5.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
6.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
7.	M / F				☐ Yes ☐ No				☐ Yes ☐ No

[1] Please check the appropriate box if the listed dependent is disabled.
[2]Not required in <State>]
[3] 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. If yes, provide details in the [Additional Information] Section

5. [Are all of the Primary Applicant's dependent children accounted for in this Application for coverage? ☐ Yes ☐ No ☐ N/A

   If no, explain: _____]

6. Is anyone applying for coverage in this Application required to provide health care coverage for a child pursuant to a qualified medical child support order or other court order? ☐ Yes ☐ No ☐ N/A

   If yes, explain:_____

7. Do all dependent children included in this Application reside with the Primary Applicant? ☐ Yes ☐ No ☐ N/A

   If no, complete the Custodial Parent section below. [Note that the Custodial Parent must also sign the [Authorization of Release of Information] and [Conditions of Enrollment] Sections of this Application.]

Child Name (Last, First, MI)	Custodial Parent Name (Last, First, MI)	Custodial Parent Address	Relationship to child
1.			
2.			
3.			

Applicant Name:_____ **Broker:**_____

PLAN SELECTION

Indicate one (1) plan selection below for which all Applicants are applying.

☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]

[Maternity benefits for this plan begin twelve (12) months from the original effective date of the policy.]
[If plan selection equals QHDHP, proceed to the Health Savings Account (HSA) Selection section]

[PRODUCT SELECTION]

[TMJ Treatment – Applicant elects to provide coverage for Medically Necessary treatment related to musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD). (AR Code 23-79-150).
☐ No ☐ Yes]

[HEALTH SAVINGS ACCOUNT (HSA) SELECTION

This section is only applicable when the plan selected in the Plan Selection section is a Qualified High Deductible Health Plan (QHDHP). If Plan Selection is not a QHDHP, skip to the Other Health Insurance Information section.]

Your Health Savings Account (HSA) is your financial asset even if you change health plans or are no longer covered by <Coventry*One*>. To open an HSA, you must meet three (3) criteria:

1. You must be covered by a Qualified High Deductible Health Plan (QHDHP);
2. You cannot be covered by another health plan, including Medicare; and
3. You cannot be claimed as a Dependent on another individual's tax return.

If you have selected a <Coventry*One*> Qualified High Deductible Health Plan (QHDHP) and are otherwise eligible, you will receive a Health Savings Account (HSA) through our HSA trustee, HealthEquity, at no additional charge. You will be able to contribute to this tax-advantaged account to help you put aside money to fund your medical claims before meeting your deductible and save for future medical expenses. As an additional benefit, HealthEquity will provide 24/7 telephonic support and online information to help you better manage this account.

If you have selected a <Coventry*One*> QHDHP product and DO NOT want to take advantage of the HSA account, please check the "OPT-OUT" box below. Otherwise, you will receive a welcome kit and HSA debit card from HealthEquity, subject to this <Coventry*One*> QHDHP Application approval and acceptance.

☐ **OPT-OUT of having an HSA opened through HealthEquity**]

OTHER HEALTH INSURANCE INFORMATION

1. Is anyone applying for coverage in this Application covered by or eligible for coverage under Medicare/Medicaid? ☐ Yes ☐ No

   If yes, list the Applicants who are covered by or eligible for coverage under Medicare/Medicaid as of the requested effective date.
   [If so, this person(s) is not eligible for coverage] ______________________________

2. Has anyone applying for coverage in this Application ever:

   A) Applied for <Coventry Plan Name> or any other Coventry Health Care plan? ☐ Yes ☐ No

   List the Applicants who have previously applied:______________________________

   B) Previously been enrolled in <Coventry Plan Name> or any other Coventry Health Care plan? ☐ Yes ☐ No

   List the Applicants who have been previously enrolled: ______________________________

   C) Currently enrolled in <Coventry Plan Name> or any other Coventry Health Care plan? ☐ Yes ☐ No

   List the Applicants currently enrolled: ______________________________

3. In the **PAST FIVE (5) YEARS**, has anyone applying for coverage in this Application had any form of life or health insurance denied, cancelled, postponed, had a waiver applied or been charged extra premium for life, disability or health

insurance, or had such insurance rescinded or involuntarily terminated, restricted or rated up? ☐ Yes ☐ No

If yes, complete information below:

Applicant Name (Last, First, MI)	Type of insurance (circle)	Name of company	Reason
1.	Health / Life / Disability		
2.	Health / Life / Disability		
3.	Health / Life / Disability		

4. Is any person applying for coverage in this Application covered by any other health insurance? ☐ Yes ☐ No

If no, skip to [Creditable Coverage] section. If yes, continue below:

Applicant Name (Last, First, MI)	Name of Company	Type of coverage (Group, Individual, COBRA, Short-Term, etc.)	Replacing other coverage?**	If yes, anticipated Policy Term Date (mm/dd/yyyy)
1.			☐ Yes ☐ No	
2.			☐ Yes ☐ No	
3.			☐ Yes ☐ No	

** Is the coverage being applied for in this Application intended to replace other carrier's coverage?
[Anyone applying for coverage in this Application having other health coverage must cancel that other health coverage upon acceptance of <Coventry*One*>, if offered. If other health coverage is not cancelled, <Coventry*One*> coverage will be terminated as of the original effective date.]
DO NOT cancel existing insurance coverage until notified in writing of approval of this Application by <Coventry*One*> .

[CREDITABLE COVERAGE AND PRE-EXISTING LIMITATION CREDIT]

[CREDITABLE COVERAGE

Under HIPAA, if anyone applying for coverage in this Application is an "eligible individual," that eligible individual(s) has the right to obtain certain individual health policies without pre-existing condition limitations and without being subject to medical underwriting. To be an eligible individual, the following requirements must be met:

Applicant name:_____

1. Individual has had coverage for at least eighteen (18) months without a break in coverage of 63 days or more; ☐ Yes ☐ No
2. Individual's most recent coverage was under a group health plan which can be demonstrated by a certificate of creditable coverage; ☐ Yes ☐ No
3. Individual's prior coverage was not involuntarily terminated because of fraud or nonpayment of premiums; ☐ Yes ☐ No
4. Individual is not eligible for COBRA continuation coverage or has exhausted COBRA benefits (or continuation coverage under a similar state provision); ☐ Yes ☐ No
5. Individual is not eligible for a group health plan or Medicare and does not have any other health insurance coverage. ☐ Yes ☐ No

Failure to answer the questions in this section accurately may result in the loss of rights as an eligible individual including the waiver of the pre-existing condition exclusion**. [It is each individual's responsibility to provide the Certificate(s) of Creditable Coverage covering the prior eighteen (18) months in order to establish HIPAA eligibility. All Certificate(s) of Creditable Coverage must be presented at the time of the Application. If unavailable at the time of Application, the Certificate(s) of Creditable Coverage should be faxed to the Coventry*One* Enrollment Department at XXX-XXX-XXXX immediately upon its receipt from issuing entity.]** [If the above creditable coverage criteria are met, and Applicant chooses to exercise their right to buy this health policy without pre-existing condition limitations, skip to [Conditions of Enrollment section]]

[APPLYING CREDITABLE COVERAGE TO PRE-EXISTING CONDITION EXCLUSION PERIOD

[If you have proof of prior creditable coverage without a break in coverage of 63 days or more and would like to use it to credit any required pre-existing condition limitation, you must include a copy of that creditable coverage document at the time of Application. Using your creditable coverage credit may result in an adjustment to your quoted rate. ☐ Yes, attachment included.]]

THE FOLLOWING SECTION IS AN EXTREMELY IMPORTANT PART OF THIS APPLICATION AND REQUIRES YOUR CAREFUL TIME AND ATTENTION TO EACH AND EVERY QUESTION BELOW. YOUR FAILURE TO PROVIDE TRUTHFUL OR ACCURATE LIFESTYLE AND HEALTH HISTORY INFORMATION COULD RESULT IN A LOSS OF COVERAGE OR OTHER PENALTIES. WE RECOMMEND THAT YOU CONSULT YOUR PHYSICIAN IF YOU HAVE ANY QUESTIONS REGARDING THE INFORMATION BEING REQUESTED BELOW.

PLEASE NOTE THAT THE INFORMATION YOU ARE PROVIDING BELOW RELATES TO YOUR LIFESTYLE AND HEALTH HISTORY AND THE LIFESTYLE AND HEALTH HISTORY OF ANY OTHER PERSON APPLYING FOR COVERAGE UNDER THIS APPLICATION.

PLEASE NOTE THE ANSWERS TO THE QUESTIONS BELOW SHOULD BE ANSWERED BY YOU AND NOT BY AN AGENT OR BROKER REPRESENTING YOU.

LIFESTYLE AND HEALTH HISTORY

Check 'Yes' or 'No,' when applicable. **Answer all questions completely**. Unanswered questions will delay or stop processing. Provide details in the [Additional Information] section. In order to process your Application, additional information may be required. A <Coventry*One* > representative may call you to discuss your Application. You may be asked to complete a questionnaire or to provide medical records. [It is the Applicants' responsibility to obtain medical records. Costs incurred to obtain medical records to process this Application are the responsibility of the Applicant.] Failure to obtain the needed information will result in our inability to process the Application.

If the health status of any Applicant herein changes between the signature date of this Application and the latter of the coverage effective date or approval date, [Coventry Health Care] must be notified of the change in writing.

LIFESTYLE QUESTIONS

1.	Is anyone listed in this Application (whether applying for coverage or not) currently pregnant, an expectant or surrogate parent, or in the process of adopting a child?	☐ Yes ☐ No
2.	Has any person applying to be covered **EVER**:	
	A) Been advised to seek treatment for alcohol use or been advised to reduce alcohol intake, or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism?	☐ Yes ☐ No
	B) Been a member of any alcohol or drug support group?	☐ Yes ☐ No
	C) Used any illegal drugs or substances, or controlled substance not prescribed by a doctor, or been counseled for, diagnosed with, or treated for drug or chemical use or dependence (including prescription, non-prescription, or illegal)?	☐ Yes ☐ No
3.	In the past **FIVE (5) YEARS**, has anyone applying for coverage in this Application been cited or convicted of driving under the influence of alcohol or any drug?	☐ Yes ☐ No
4.	Within the past 12 months, has any person to be covered consumed alcoholic beverages? (*Note: Even if only on occasion, please provide the number of drinks consumed on such occasions*.) Applicant Name _____ Number of drinks consumed per week: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36 or more Applicant Name _____ Number of drinks consumed per week: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36 or more Applicant Name _____ Number of drinks consumed per week: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36 or more	☐ Yes ☐ No
5.	Has anyone applying for coverage in this Application **EVER** been convicted of a felony, or been on, or is currently on probation? If yes, identify the person and details in the [Additional Information] Section.	☐ Yes ☐ No
6.	[In the past **TWO (2) YEARS**, has any person applying for coverage in this Application piloted a private aircraft or participated in skydiving or scuba diving, motor vehicle, boat or snowmobile racing, rock or mountain climbing, hang gliding, rodeos or any other hazardous sports activities? If yes, provide details in the [Additional Information] Section.]	☐ Yes ☐ No

If any **lifestyle** questions were answered with 'yes,' the following information must be completed. Please explain and provide **FULL DETAILS** for each 'yes' answer to any of the preceding **lifestyle** questions and **INDICATE TO WHICH APPLICANT THE INFORMATION APPLIES.** If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Q #	Applicant Name (Last, First, MI)	Details of answer: Conditions, treatment, convictions, etc. (Indicate number of occurrences)	Start Date (mm/yyyy)	End Date (mm/yyyy)

Applicant Name:_____ **Broker:**_____

HEALTH QUESTIONS

7. Within the past ten (10) years, has anyone applying for coverage in this Application had any signs or experienced symptoms that caused them [or would cause an ordinary prudent person] to seek advice, treatment or therapy, or consulted or sought medical treatment, been diagnosed, had medical treatment recommended, received medical treatment or therapy, been surgically treated, or been hospitalized for any of the following conditions:	
A) Cancer**, including but not limited to**: melanoma, Hodgkin's disease, malignant sarcomas, carcinomas, tumors or cysts? If "Yes", provide location, type, stage, and treatment in the [Additional Information] Section.	☐ Yes ☐ No
B) Heart attack, heart disease, stroke, aneurysm, multiple sclerosis, or hepatitis B or C; or been a candidate or a recipient of an organ or bone marrow transplant? If "Yes", specify which organ, and/or if bone marrow transplant in the [Additional Information] Section.	☐ Yes ☐ No
C) Had any implants (breast or penile), devices such as pacemakers, shunts, stents, valve replacements, monitoring devices or internal fixation devices (plates, pins or screws) or prosthetics? If breast implant, specify type: ☐ Silicone ☐ Saline	☐ Yes ☐ No
8. Within the past **TEN (10) YEARS**, has anyone applying for coverage in this Application had any signs or experienced symptoms that caused them [or would cause an ordinary prudent person] to seek advice, treatment or therapy, or consulted or sought medical treatment, been diagnosed, had medical treatment recommended, received medical treatment or therapy, been surgically treated, or been hospitalized for any of the following conditions:	
A) Cardiovascular disorders, **including but not limited to**: hypertension, or high blood pressure, chest pain, heart murmur, mitral valve prolapse, palpitations or heart rhythm disturbance or surgery? If history of hypertension, high blood pressure or elevated blood pressure readings, provide three (3) blood pressure readings and dates, including the highest reading within the last **SIX (6) MONTHS.** These readings must have been taken by a physician. Date _____ Reading _____ Date _____ Reading _____ Date _____ Reading _____ Highest reading in last SIX (6) MONTHS: Date _____ Reading _____	☐ Yes ☐ No
B) Blood disorders, **including but not limited to**: anemia, hemophilia, purpura, thrombocytopenia, leukemia, sickle cell anemia, abnormal white or red blood cells or abnormal bleeding?	☐ Yes ☐ No
C) Vein or artery disorders, **including but not limited to**: phlebitis, thrombosis, varicose veins or ulcers, peripheral vascular disease or clots and poor circulation?	☐ Yes ☐ No
D) Connective tissue disorders, **including but not limited to**: systemic (SLE) or discoid lupus, scleroderma, rheumatoid arthritis, CREST or Sjogren's syndromes?	☐ Yes ☐ No
E) Cerebrovascular disorders, **including but not limited to**: stroke, transient ischemic attack (TIA), carotid bruits, or cerebral (brain) hemorrhage?	☐ Yes ☐ No
F) Immune or lymph system disorders, **including but not limited to**: persistent lymph node enlargement, persistent fever, persistent diarrhea, persistent fatigue, or weight loss of unknown cause? Have you or anyone applying for coverage been positively diagnosed or treated for acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV)?	☐ Yes ☐ No
G) Nervous system disorders, **including but not limited to**: headaches, migraines, dizziness, epilepsy, fainting, tremors, convulsions, seizures, paralysis, autism, Alzheimer's, Parkinson's, amyotrophic lateral sclerosis (ALS) or cerebral palsy?	☐ Yes ☐ No
H) Respiratory system disorders, **including but not limited to**: asthma, sinusitis, allergic rhinitis, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), dyspnea, tuberculosis, sarcoidosis or sleep apnea?	☐ Yes ☐ No
I) Metabolic or endocrine disorders, **including but not limited to**: obesity, elevated lipids (cholesterol, triglycerides), Diabetes or sugar intolerance; disorder of the thyroid, pituitary, adrenal, pancreas or other gland or goiter?	☐ Yes ☐ No
J) Musculoskeletal disorders, **including but not limited to**: arthritis, fibromyalgia, gout, back, neck or spinal column disorders such as herniated disc(s); osteopenia/osteoporosis, ankylosing spondylitis, fractures, dislocations or disorders, polio/post-polio syndrome, muscular dystrophy, amputation, or persistent or recurring pain of the muscles, bones or joints or had spinal adjustments or manipulation therapy?	☐ Yes ☐ No
K) Urinary tract disorders, **including but not limited to**: kidney or bladder stones, cystitis or other urinary tract infections, urethral stricture or stenosis, kidney transplant or dialysis, renal failure or polycystic kidney disease?	☐ Yes ☐ No
L) Hernias, **including but not limited to**: inguinal, scrotal, hiatal (diaphragmatic) or umbilical?	☐ Yes ☐ No
M) Female reproductive system disorders, **including but not limited to**: infertility, irregular menstruation, uterine fibroids, uterine prolapse, endometriosis, abnormal PAP smears, caesarian section or other complications of pregnancy? Date / results of most recent PAP smear: Date (mm/yyyy): _____ Results: _____ Date / results of first prior PAP smear: Date (mm/yyyy): _____ Results: _____	☐ Yes ☐ No

Applicant Name:_____ **Broker:**_____

N) Ear, eye, nose, throat or skin disorders**, including but not limited to:** recurrent ear infections, Meniere's disease, deafness, blindness, cataracts, detached retina, glaucoma, optic atrophy, deviated nasal septum, nasal polyps, psoriasis, acne or skin tumors?	☐ Yes ☐ No
O) Breast disorders, **including but not limited to:** breast cysts or tumors, fibrocystic breast disease, gynecomastia, mastitis or abnormal mammograms?	☐ Yes ☐ No
P) Male reproductive disorders, **including but not limited to:** prostate disorder(s), elevated PSA testing, erectile dysfunction, infertility or male genital disorder?	☐ Yes ☐ No
Q) Mental or nervous disorders, **including but not limited to:** attention deficit disorder, anxiety, depression, eating disorders, bipolar disorder, schizophrenia or psychotic disorder?	☐ Yes ☐ No
R) Intestinal or rectal disorders, **including but not limited to**: Crohn's disease, ulcerative colitis, intestinal polyps, hemorrhoids, irritable bowel syndrome (IBS), diverticulitis / diverticulosis?	☐ Yes ☐ No
S) Sexually transmitted diseases, **including but not limited to**: gonorrhea, chlamydia, human papillomavirus (HPV), syphilis, genital warts or genital herpes?	☐ Yes ☐ No
T) Digestive system disorders, **including but not limited to**: gastroesophageal reflux disease (GERD), esophageal stricture, esophageal varices, cirrhosis or other liver disorder, spleen disorder, stomach or duodenal ulcer(s), gallbladder disease or gall stones?	☐ Yes ☐ No
U) Abnormal diagnostic tests, **including but not limited to:** abnormal blood tests, abnormal MRI or CT scan, x-ray, bone density, abnormal electrocardiogram (EKG) or echocardiogram?	☐ Yes ☐ No
9. Within the past **FIVE (5) YEARS**, has any person applying for coverage in this Application:	
A) Consulted or been examined or treated by any physician, chiropractor, psychologist, or other health care practitioner?	☐ Yes ☐ No
B) Been to a clinic, hospital, emergency room, or other medical facility for treatment, confinement, or observation?	☐ Yes ☐ No
C) Plan to, had, or been advised to have a procedure, tests or treatment that have not yet been performed?	☐ Yes ☐ No
D) Had any disease, disorder, ailment, injury or condition not listed in this Application for which there have been, or are plans or intentions to seek advice, diagnosis, or treatment?	☐ Yes ☐ No

PRESCRIPTION MEDICATIONS AND INJECTION THERAPY

List all medications and injection therapy taken or prescribed within the last **TWELVE (12) MONTHS** for any Applicant listed on this Application. Please include any over-the-counter (OTC) medications taken on a regular basis. If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Applicant Name (Last, First, MI)	Medication / Dosage / Frequency (e.g., Lopressor™ / 100mg / daily)	Reason Prescribed / Taken	Date Prescribed (mm/dd/yyyy)	Still taking?	Date discontinued (mm/dd/yyyy)	Name, Address and Phone Number of Prescribing Physician
				☐ Yes ☐ No		
				☐ Yes ☐ No		
				☐ Yes ☐ No		
				☐ Yes ☐ No		
				☐ Yes ☐ No		

ADDITIONAL INFORMATION

If any **health history** questions were answered with 'yes,' the following information must be completed. Please explain and provide **FULL DETAILS** for each 'yes' answer to any condition(s) checked in the preceding questions and **INDICATE TO WHICH APPLICANT THE INFORMATION APPLIES.** If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Q #	Applicant Name (Last, First, MI)	Conditions, treatment, operations (Indicate number of occurrences)	Date of onset (mm/yyyy)	Date of recovery (mm/yyyy)	Days in hospital	Last checkup for condition (mm/yyyy)	Results	Name, Address and Phone Number of Health Care Provider

NAMES OF HEALTH CARE PROVIDERS NOT LISTED ABOVE

Applicant Name (Last, First, MI)	Name, Address and Phone Number of Health Care Provider	Details of Last Visit		
		Date (MM/YYYY)	Reason for Visit	Result (Circle one. If abnormal, explain)
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal

Applicant Name:_____ **Broker:**_____

CONDITIONS OF ENROLLMENT

I represent that all information on this Application form is complete and accurate and true to the best of my knowledge. I understand that my answers to the questions on this form will be used as the basis to determine eligibility for coverage. I further understand that if any information is omitted or misrepresented, it could provide the basis to refuse, reform or rescind coverage and to adjust as applicable, or refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits. [I understand that if my Application for coverage is declined, I may not apply for <CoventryOne> coverage for six (6) months.] I understand that if my health or any of the answers or statements provided herein change between the signature date of this Application and the latter of the coverage effective date or approval date, I must inform <Coventry*One*> of such in writing. I understand that failure to do so may result in the denial, reformation or rescission of coverage.

I understand and acknowledge that the selling agent, if applicable to this Application for coverage, has no authority to promise coverage to Applicants herein or to modify <Coventry*One*> underwriting policy or the terms of <PLAN> coverage.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

THE EFFECTIVE DATE OF COVERAGE OF APPLICANTS LISTED HEREIN IS ASSIGNED BY <COVENTRY*ONE*> AT ITS DISCRETION, SUBJECT TO MEDICAL UNDERWRITING; AND AN OFFER OF COVERAGE AND PREMIUM AMOUNT BEING PRESENTED AND ACCEPTED.

DO NOT CANCEL EXISTING INSURANCE COVERAGE UNTIL NOTIFIED IN WRITING BY <PLAN> OF APPLICATION APPROVAL.

PRIMARY APPLICANT'S SIGNATURE	DATE	**SPOUSE'S SIGNATURE** (If applying for coverage	DATE
DEPENDENT APPLICANT SIGNATURE*	DATE	**DEPENDENT APPLICANT SIGNATURE***	DATE

*Required age 18 and over.

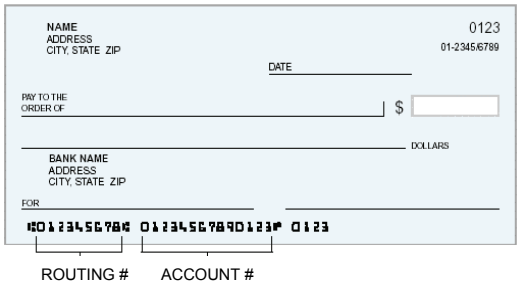
If minor child-only application (under the age of 18), this section must be signed by the minor child (children's) parent or legal guardian identified in the Applicant and Dependent Information Section. ☐ **Check here if N/A**

PARENT / LEGAL GUARDIAN SIGNATURE	**PRINT NAME**	**RELATIONSHIP TO APPLICANT**	**DATE**

PREMIUM PAYMENT

Premiums due for coverage under a policy pursuant to the approval of this Application and acceptance of coverage will be paid from funds automatically deducted from either a checking or savings account, upon the Account Holder's authorization herein, subject to the <Plan> approval of this Application and the acceptance of an offer coverage. To facilitate the premium withdrawal this section must be completed in its entirety. This payment information does not guarantee approval or coverage.

Please Provide: ☐ Checking Account ☐ Savings Account



Name of Bank or Savings Institution: _____

9-Digit Routing Number: |___|___|___|___|___|___|___|___|___|

Account Number: _____ _____
[(A voided check or savings account deposit slip should be attached in support of content in this section)]

Name of Account Holder: _____

Relationship of Account Holder to the Primary Applicant: ☐ Self ☐ Spouse ☐ Other _____

Permanent Address of Account Holder: _____

_____

Applicable Premium amount is automatically withdrawn from the account provided herein on the 10th day of each current coverage month, or next business day. The initial premium withdrawal may not occur until the 10th of the month following the first month of coverage and will account for the total amount owed from the original effective date. For example, if the first months' premium is calculated beginning on the 15th of the month but not withdrawn until the 2nd month of coverage, the amount due in the 2nd month will equal one and one half (1½) the total monthly premium amount. If the first months' premium is calculated beginning on the 1st of the month but not withdrawn until the 2nd month of coverage, the amount due in the 2nd month will be twice the total monthly premium amount.

If premium payment is returned unpaid a Return Check Fee amount will be assessed in the amount of [$20.00]. Account Holder hereby authorizes <Plan> to collect the premium payment due on the [20th] of the month, or next business day, including the Return Check Fee amount, via electronic funds transfer (EFT) or automatic withdrawal from the account identified and provided herein or then current.

By signing below, I authorize <PLAN > to initiate automatic withdrawal of applicable premium payments from the account listed above.

I, the Account Holder, acknowledge and understand that it is my responsibility to notify <Plan> at [<insert #>] should the payment information provided herein change while a policy of coverage pursuant to this Application remains in force and effect.

Account Holder Signature:_____ **Date:**_____

[BROKER INFORMATION]

The following sections are to be completed by the broker.

[Broker Name:]	[Broker ID #:]	[Broker Email Address:]
[Broker Signature:]	[Agency Name:]	[Broker/Agency Phone: ( )]
[Name of General Agent:]	[Payee (who is paid the commissions) ☐ Broker ☐ Agency ☐ General Agent]	[Payee Tax ID#]

[PRODUCER CERTIFICATION]

[[I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this Application or any supplement to it. I have not advised the Applicant to withhold any information regarding the answers to the questions and have advised the Applicant to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that all my answers recorded above are correct, complete, and wholly true to the best of my knowledge and belief.

Producer Signature _____ **Date**_____]

[AUTHORIZATION OF RELEASE OF INFORMATION]

[I, for myself and any of my Dependents who are under the age of 18 who and are applying for coverage hereunder, hereby make the following authorizations:
I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to <PLAN> or its authorized representatives, my (or my Dependents') personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I also authorize the release of information relating to mental illness.
In addition, I authorize <PLAN> to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by <PLAN> for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for <PLAN> to consider my Application and to determine whether or not an offer of coverage will be made. No action will be taken on my Application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by <PLAN> as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request.
I authorize <PLAN> to use or disclose the information I provide in this Application (or that the <PLAN> has or receives from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by law. Any revocation will not affect the activities of <PLAN> prior to the date such revocation is received by <PLAN>.]

PRIMARY APPLICANT'S SIGNATURE	DATE	**SPOUSE'S SIGNATURE** (If applying for coverage)	DATE
DEPENDENT APPLICANT SIGNATURE*	DATE	**DEPENDENT APPLICANT SIGNATURE***	DATE

*Required age 18 and over.

If minor child-only application (under the age of 18), this section must be signed by the minor child (children's) parent or legal guardian identified in the Applicant and Dependent Information Section. ☐ **Check here if N/A**

PARENT / LEGAL GUARDIAN SIGNATURE	**PRINT NAME**	**RELATIONSHIP TO APPLICANT**	**DATE**

Applicant Name:_____ **Broker:**_____

SERFF Tracking Number:	*GHPI-126234201*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*42938*
Company Tracking Number:	*GSAPP09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*App09*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GHPI-126234201*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*42938*
Company Tracking Number:	*GSAPP09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*App09*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification

Review Status: Approved-Closed 07/22/2009

Comments:

Attacheds is the Flesch certification for this filing.

Attachment:

Flesch Certification.pdf

Bypassed -Name: Application

Review Status: Approved-Closed 07/22/2009

Bypass Reason: N/A Filing is the applications

Comments:

Bypassed -Name: Health - Actuarial Justification

Review Status: Approved-Closed 07/22/2009

Bypass Reason: N/A Filing is only an application.

Comments:

Bypassed -Name: Outline of Coverage

Review Status: Approved-Closed 07/22/2009

Bypass Reason: N/A Filing is only an application.

Comments:

READABILITY CERTIFICATION

I hereby certify that the following forms comply with the Arkansas minimum Flesch reading ease test scores pursuant to A.C.A. § 23-80-206:

MGSA_0609 CHARK 00007

(Signature) Assistant Secretary, Coventry Health & Life Insurance Company

Jonathan D. Weinberg

(Print Name)

July 21, 2009

(Date)